

**COMMONWEALTH OF VIRGINIA  
SCHOOL ENTRANCE HEALTH FORM**

**Part II - Certification of Immunization**

***Section I***

**To be completed by a physician or his designee, registered nurse, or health department official.  
See Section II for conditional enrollment and exemptions.**

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.

Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*Last*
*First*
*Middle*
*Mo.*
*Day*
*Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6 <sup>th</sup> grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official: \_\_\_\_\_ Date (Mo., Day, Yr.): \_\_\_\_/\_\_\_\_/\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section II**  
**Conditional Enrollment and Exemptions**

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

**MEDICAL EXEMPTION:** As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

\_\_\_\_\_  
\_\_\_\_\_  
DTP/DTaP/Tdap: [ ]; DT/Td: [ ]; OPV/IPV: [ ]; Hib: [ ]; Pneum: [ ]; Measles: [ ]; Rubella: [ ]; Mumps: [ ]; HBV: [ ]; Varicella: [ ]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (Mo., Day, Yr.): \_\_\_\_/\_\_\_\_/\_\_\_\_.

Signature of Medical Provider or Health Department Official: \_\_\_\_\_ Date (Mo., Day, Yr.): \_\_\_\_/\_\_\_\_/\_\_\_\_

**RELIGIOUS EXEMPTION:** The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

**CONDITIONAL ENROLLMENT:** As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on \_\_\_\_\_.

Signature of Medical Provider or Health Department Official: \_\_\_\_\_ Date (Mo., Day, Yr.): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section III**  
**Requirements**

**For Minimum Immunization Requirements for Entry into School and  
Day Care, consult the Division of Immunization web site at  
<http://www.vdh.virginia.gov/epidemiology/immunization>**

**Children shall be immunized in accordance with the Immunization Schedule developed and published by  
the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the  
American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP),  
otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).  
(Requirements are subject to change.)**

### Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at [www.vahealth.org/schoolhealth](http://www.vahealth.org/schoolhealth).

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: ☐ M ☐ F

<b>Health Assessment</b>	<b>Date of Assessment:</b> ____/____/____ <b>Weight:</b> _____ lbs. <b>Height:</b> _____ ft. _____ in. <b>Body Mass Index (BMI):</b> _____ <b>BP</b> _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	<b>Physical Examination</b> 1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment <table style="width: 100%; text-align: center;"> <tr> <td></td> <td>1</td> <td>2</td> <td>3</td> <td></td> <td>1</td> <td>2</td> <td>3</td> <td></td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>HEENT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neurological</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Skin</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abdomen</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Extremities</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Urinary</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<b>TB Screening:</b> <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease <input type="checkbox"/> Risk for TB infection or symptoms identified																																																		
<b>Test for TB Infection:</b> TST IGRA Date: _____ TST Reading _____ mm    TST/IGRA Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <b>CXR required if positive test for TB infection or TB symptoms.</b> CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																																																		
<b>EPSDT Screens Required for Head Start – include specific results and date:</b> <b>Blood Lead:</b> _____ Hct/Hgb _____																																																		

<b>Developmental Screen</b>	Assessed for:	Assessment Method:	Within normal	Concern identified:	Referred for Evaluation
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				

<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: ____ Left ____ Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
	L				
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (check if yes)					<b>Dental Screen</b>	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
	Stereopsis	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested			
	Distance	Both	R	L	Test used:		
		20/	20/	20/			
	<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen						

<b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b>	<b>Summary of Findings (check one):</b> <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____	
	<b>Allergy</b> <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____	
	<b>Individualized Health Care Plan needed</b> (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	<b>Restricted Activity Specify:</b> _____	
	<b>Developmental Evaluation</b> <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	<b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.	
	<b>Special Diet</b> Specify: _____	
	<b>Special Needs</b> Specify: _____	
	<b>Other Comments:</b> _____	

<b>Health Care Professional's Certification</b> (Write legibly or stamp) <input type="checkbox"/> By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).	
Name: _____	Signature: _____ Date: ____/____/____
Practice/Clinic Name: _____	Address: _____
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____ Email: _____